MENTAL HEALTH OVERSIGHT AND ADVISORY COUNCIL
July 20 – 21, 2004
Addictive and Mental Disorders Conference Room

Members Present: Leslie Edgcomb, Chuck Hunter, Senator Gerald Pease (July 20 only), Janet Kelly, Dr. Don Harr, Tom Peluso, Joyce deCunzo, Drew Schoening, Melanie Martin-Dent, Jo Shipman, Barbara Hogg, Jacob Wagner, Suzanne Hopkins, Larry Noonan, Jenny Lynch

Members Absent: Senator Bob Keenan, Mignon Waterman, Senator John Esp, John Chappuis, Leroy Bingham, John Lynn

Facilitator: John Mundinger

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ACTION	FOLLOW UP
Bob Mullen, AMDD	Budget Status Update: closing the books on FY2004 – AMDD will revert approximately $900,000 in General Fund.		
Joyce de Cunzo: Legislative Proposal: Montana State Hospital preadmission screening	The proposal provides for the ability to review an admission and make determination of its appropriateness before the patient arrives at MSH. Joyce reviewed ongoing census concerns (averaging 189+) and consequential quality of care issues that are the result of patient crowding. MSH needs to have a census that allows for adequacy of staffing and quality treatment. There is no draft legislation at this time – opposition is anticipated. Lois Steinbeck reminded the council that EMTALA must be addressed in	Council members recommended that AMDD develop a clear definition of the problem(s), and put its time and energy into developing alternatives in the community including local crisis management, standardization of county procedures and criteria. The best solutions will come through working with communities to develop resources. The census at MSH is a symptom of a lack of capacity in the community. AMDD needs to contract for a prevalence study to determine	

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	any legislation. Additional comments are included in an attachment to these minutes. AMDD was criticized for not using existing intensive community group home beds for MSH overflow. AMDD has approved MSH patients for this level of care when eligibility is effective.	what the capacity needs to be.	
Chuck Hunter and Duane Preshinger: Medicaid Preferred Drug List	Mental health drugs make up 35% - 40% of the Medicaid pharmacy budget. There is a need to balance the unique and special needs of people with mental illness with fiscal responsibility. A solution can only be found by working together. Mental Health Preferred Drug List Workgroup has been formed. First meeting will be July 23. More information will be available at the September MHOAC meeting.	Jenny Lynch was asked to join the group as a consumer representative.	
Committee Reports			
AMDD Standing Report – Joyce deCunzo	See handout from meeting: "Addictive and Mental Disorders Division Report, July 30, 2004"		
Children's System of Care – Chuck Hunter	See handout from meeting: "Child and Adult Health Resources Division – Report to MHOAC, July 19, 2004"		
Medicaid Redesign – Gail Gray	Report and recommendations are going to print very soon		
Ombudsman – Bonnie Adee	Handout on 5-year trends Discussion of statutory responsibility for crisis services by DPHHS and CMHCs		Develop definition of crisis service

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Adult Committee – Jenny Lynch	Ongoing discussion with Corrections and mental health centers to assure that individuals discharged from MSH and MSP are getting services, community support, help with housing. Suicide prevention hotline – want a statewide system and committee will review Voices of Hope standards and proposal for legislative recommendations.		
Block Grant – Marcia Armstrong	Review of history of Block Grant (Marcia) and Data Infrastructure Grant and URS tables (Bobbi). Basics of Plan include the following: 1. Analysis of unmet service needs/gaps 2. Strengths/weaknesses of service system 3. Practices/plans to address unmet needs 4. Achievements 5. System as envisioned by state in the future Block Grant application will be for three-year period. Mental health vision statement developed for adult system.	See attachment Modifications needed for children's mental health system – family focused; resiliency	Draft Plan will be sent to Council members – comments due back to Marcia by August 20.
Legislative Proposal: Crisis Hot Line	Council supports a legislative proposal to fund Voices of Hope hotline on a statewide basis. Concern about the restrictions/limitations that would		

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	emerge from legislation. Discussion of including funding in HB2 without enabling legislation – potential that money could be moved to some other program.		
SAA/KMA Coordination Concept Paper – Joyce deCunzo and Chuck Hunter	SAAs and KMAs can co-exist, but there is a disconnect in 2 statutes that should be resolved. Discussion about identifying the "controlling legislation", function and role of each entity, ability to work together rather than attempt to dominate.	Agreement to pursue Option 2a,b, and c	Follow-up with System of Care Committee, SAA subcommittee MHOAC
Joyce de Cunzo: AMDD Strategic Plan	See handout from meeting: "Strategic Plan for Adult Mental Health Services" Commend AMDD's plan to review function of 3 facilities; need goal that addresses need for recruitment and retention of staff	Council endorsed plan as presented	
CHIP Coverage for TYCM and Family Support Services – Children's Committee Report	Committee was not ready to report	Place on agenda for September meeting	
LAC Policy	Current policy draft and changes were distributed	Approved by Council	

Next meeting: September 14, 2004
Board of Investments Conference Room
2401 Colonial Drive – 3rd Floor

Pre-Admission Screening Discussion

- We should commit people to the SAA and let the SAA make the determination about appropriate placement.
- Contract for beds with private providers throughout the state as an alternative to expanding the capacity at MSH.
- Work closely with MHP teams
- There should be more consistency in the commitment process.
- There are problems related to medications at the time of arrest – there should be a standard crisis response related to medication management.
- Focus on developing alternative services, especially in those communities with a high rate of admissions.
- Fully explore all ramifications of pre-admission screening legislation.
- There should be a standardized screening process; including an assessment of community capacity to serve the needs of the person under consideration for admission to MSH.
- The screening process works better for involuntary commitments than it does for emergency commitments.
- Many emergencies result because communities lack capacity to serve the needs of people in their community.
- Think about the issue from the perspective of the individual consumer.
- We can't close one gate without first opening other gates, e.g. provide more support for crisis teams, community education, etc.
- County jails should be more accountable to national health care standards.
- It is not possible to completely eliminate the "bad days" at MSH.
- Cynical perspective: are we using the MSH census as another "bait and switch"? We need to present a proposal that can work and can be implemented in the community. What can we learn from the Lewistown experience? Could we use vacant beds that were developed to provide one kind of service to serve people who otherwise might be committed to MSH?
- We need to promote standard policies, e.g. medication management for people in jail.
- We need to provide more support to the communities to help with medication management.
- Focus on solving the problems in those communities that are high users of MSH.
- Evaluate the discrepancies between the involuntary and emergency commitment processes.
- We need support and encouragement for local government to follow standard procedures.
- We need to balance the financial risk of have an over-population at MSH and the financial risk associated with denying service.

- There should be copies of the PDR in every county jail.
- The requirements for BHIFs are onerous. Can we ease some of the requirements to make it easier for potential bidders to respond to the RFP?
- We have been talking about adults. What about kids?
- Redirect cost savings at MSH to support community services.
- Many of the crises result because we do not have adequate psychiatric services in Montana. People do not have sufficient help with their medication management.
- How large is the forensic population and how does this population affect the MSN census? The forensic population would not be affected by pre-admission screening.
- Appropriate crisis response is a local/regional issue and not really a statewide problem. Start locally and provide more support for helping communities develop solutions that will work in their community.
- The MSH census is not the problem, but a barometer – there is a lack of capacity n the communities. We need a better understanding of the number of people in Montana who meet the SDMI definition.
- We need to better define the unique role of MSH and the support that is necessary to make it possible for MSH to play that role.
- Could we make better use of vacant group home and adult foster care beds?
- We need more outside agency involvement on the MSH campus, e.g. voc. Rehab
- We need support from the Governor's office, including the economic development potential associated with the provision of mental health services.
- Training for law enforcement has been a positive step. We should continue on a course to promote better partnerships with local government.
- We need better data on people who are served at MSH.

Mental Health Block Grant: Adult Plan

Criterion 1

- Choice – facilitate choice and options
- Consistency of services in a frontier state
- Crisis services – definition, capacity, etc.
- Accessibility to services is paramount
- Employment
- Co-occurring disorders
- Psychiatric services availability
- Consistency of care in detention facilities
- Continuing education to public regarding mental health
- Overcome stigma
- Housing
- Identify the invisible seriously mentally ill – outreach
- Transition of mentally ill from prison to the community
- Department management to reduce fragmentation and set direction
- No wrong door to the system
- Transitions between different components of the system
- Recognition of multiple primary diagnoses and appropriate coordination of services
- Habilitation process as opposed to a rehabilitation; supportive service – get the medical definition of rehabilitation out of the recovery concept; learning to cope rather than cure
- Defining and delivering community based services through the SAA process
- Develop and support peer services
- Support the HUB
- Transportation; assistance with travel costs, etc.
- Adequate case management

- Methods to get people to eligible services to move towards recovery – presumptive eligibility; pass plan; Voc-rehab; supportive employment, etc.
- Physical health care for people with mental illness

Criterion 2

- # eligible for services
- # persons who are provided with services
- Track data by primary and secondary diagnoses
- Address concerns related to chasing dollars with diagnoses
- Define the universe of people whom we are trying to serve; define what we need to know about those people
- Prevalence study – who are the unknowns?
- Sort by age/region/rural v. urban
- Align the people whom we are trying to serve with the capacity of the system to serve those people.
- Evaluate information from those who are denied service. Who are the people who present themselves; what are they requesting; what are their outcomes; etc.?
- How many SED children become SDMI? What happens to kids who age out of the children's system?
- How many families have parents in the adult system and children in the children's system?
- Clarify the distinction between rural and urban; identify the corresponding populations
- Data on the PATH program
- Outcome measures to include employment, housing, relationships, etc.; frequency of services
- What proportion of individuals with SDMI are served by the 4 CMHCs and Aware.
- Track SDMI and prison system with those who are SDMI.
- Who is the co-occurring population?

Criterion 4

- Size of the community should not dictate the quality of services
- Adequate case managers for PATH to provide outreach
- Develop plan for distribution of outcome measures

- Continuum of Care Coalition
- Develop outcome measures
- Diversity of services for those who prefer to remain homeless and those who desire housing
- Better education and coordination with law enforcement; they are the first responders for homeless people
- Continue to look at providing services to those frontier counties
- Triage and develop a plan to better spend the limited PATH funds.
- Explore coordination among PATH workers and adult protective services
- Adequately address the mileage component which providing services in rural communities.
- Coordination with other organizations that work with homeless people
- Connect people to the service – either bring the service to the community or get the person to the service.

Criterion 5

- More psychiatric services throughout the state
- Put mental illness training into the curriculum of EMTs, etc.
- MLEA – more training on mental health
- CTI (Memphis) training for law enforcement
- Identify the training needs of providers and implement a plan to incorporate training for them
- Provide training to providers of our expectations.
- MPA survey constituents on training needs
- Make better use of Telemedicine
- Training to reduce stigma
- Standards are established and set for the training; standard policies and protocols
- Involve mental health training with CEU's – including certain hours for continuing education of mental health
- Make sure adequate financial resources are available in rural areas.
- Financial incentives to keep staff in rural communities.
- Look at a mileage formula for those in rural areas
- Global responsibility – perhaps seek additional funds through the Legislature.

Mental Health Block Grant: Children's Plan

Criteria 1

- School and school dropouts – effective school based services; every school has to have a homeless coordinator
- Transition
- Family support services; respite services, etc.
- Awareness and training for preschool and head start teachers
- Coordinate services for the adult with SDMI and child with SED
- Provide case management services for those non-Medicaid children with SED
- Need for medical and dental services for children
- Clinical training for school counselors
- Gate keeping education for school administrators, teachers and staff, etc. for suicide prevention, violence, mental illness, chemical dependency – i.e. school staff who understand how to redirect students into the appropriate services
- Systems of care – make it happen
- We hope there are no holes in the "SOCS"
- Early entry into the system
- Services for teenagers with children
- Prevention services; early intervention for the walking wounded
- Ensure IEPs are sensitive to mental illness and follow through; work on confidentiality of IEP
- EPSDT – especially for those in jeopardy
- Connecting to employment
- OPI general education of mental illness to address stigma – school personnel and students
- Recognize early signs of substance abuse and developmentally disabled
- School based peer counseling
- Expansion of rehabilitation services
- Kids receiving unnecessary and/or inappropriate medications
- Inappropriate diagnoses

- Special Ed funding need to be better maximized.
- Coordinate with OPI
- Transitioning kids to adult system – maintain medication during transition
- Center based/home based training on cognitive behavior
- Psychiatrists do more with consultation services; primary doctors
- Goals on access to care
- Involve parents at all levels; local planning
- Involve youth at all levels
- Children being the owner of their plan; teach children to actively participate
- EPSDT – where are we going to get the biggest bang for the buck?
- Continue to work toward statewide parent organization; family support/parent support group
- Waiver based services
- Develop youth council
- Need to define those kids that have committed a crime and are assigned to the department
- When the court commits a child as an involuntary; no state hospital system; what is done with these kids
- What do we do with kids that are custody of department and have recovered but the department still has custodial authority; eligibility and financial issues
- Justice/probation
- Custody/adoption issues; those kids adopted out of child/family services; support up to age 18 and then dropped
- Developmental work with KMA/SAA
- Transportation/accommodations for kids and family when seeking services

Criteria 2

- Educational outcomes; better define for focus
- Identify appropriate benchmarks; SOCS is working on this
- What do we want to seek as educational outcomes? # graduated; # receiving GED; # days attended; # drop out/age
- # in home and receiving services
- # out of home care/average duration of placement/multiple placements

- # of kids whose parents have SMI
- Family relationships
- # estimated eligible
- # receive services
- # kids seeking services but denied
- What can we learn from high cost study and apply to data
- Primary/secondary diagnoses
- Aggregate data; getting data from funding sources
- How many homeless
- Suicide prevalence and attempted suicides
- Look at homelessness definition as applies to kids
- Information on receiving services instate and out of state
- Sort by county/age/region
- Why are we sending kids out of state? What are the dynamics? Native American issues; how can we access this population and bring to the table

Criterion 4

- Reimburse case managers in rural communities for travel
- Homeless v. runaway

Criterion 5

- Reimbursement for providers
- Cost based reimbursement
- Training/certification; career path for case managers
- School-based; confidentiality and funding
- Training and development needs/changes for providers
- Evidence based models
- Talk about the distribution of black grant; funding equitability

- Provider rates